Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Dunwiley & Cloghan
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Short Notice Announced
Date of inspection:	13 July 2020
Centre ID:	OSV-0005489
Fieldwork ID:	MON-0029848

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Dunwiley and Cloghan provides full-time residential care and support to male and female adults. The designated centre comprises of a six bed bungalow and a four-bed bungalow. The four bed bungalow also has a separate one bed self-contained apartment attached. The centre is located within a small campus setting which contains three other designated centres operated by the provider. The centre is located in a residential area of a town and is in close proximity to amenities such as shops, leisure facilities and coffee shops. There are two buses available for residents to travel to appointments or shops if they wish. Residents are supported by a staff team of both nurses and care assistants. During the day, support is provided by seven staff (five in one bungalow and two in the other). At night residents are supported by two staff members in each bungalow. Nursing care is provided on a 24/7, basis meaning a nurse is allocated in each bungalow during the day and at night. The person in charge is responsible for two other designated centres and is supported by a clinic nurse manager 2 who is full time in this centre to ensure effective oversight of the services being provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 13 July 2020	10:50hrs to 17:30hrs	Anna Doyle	Lead

What residents told us and what inspectors observed

The inspector only visited one of the units in this designated centre due to current COVID-19 recommendations. Residents were asked if they wanted to meet with the inspector to talk about their views on the services being provided in the centre. One resident wanted to talk about this and other residents spoke informally to the inspector.

Overall the feedback was positive and residents said they liked living in the centre and liked the staff who supported them. They spoke about some of the activities they liked and about the current pandemic health crisis. Some spoke about enjoying going shopping and out for coffee. One resident said that they go shopping once a week. Another resident spoke about a shopping trip planned for two weeks time.

A review of residents' personal plans found a number of other activities that residents were interested in. Some of those activities were restricted as a result of COVID-19. In response the staff had revised goals for residents to ensure they had meaningful activities despite the restrictions. Some of the goals developed included; baking, gardening, exercising and increasing independence in daily living skills. One resident went out for a drive on the day of the inspection and another resident was exercising. However, there was limited activities being recorded for residents in the centre. For example; two residents plans showed that while residents had been out for a drive most days over a two week period, there was limited activities taking place in the centre otherwise. The inspector also noted that when staffing levels were reduced in the centre (as was the case on the day of the inspection) there was insufficient staff in place to support residents should they wish to avail of activities.

Residents and staff were interacting in a warm and friendly manner. It was evident that staff knew the residents well and residents appeared very comfortable in the presence of staff.

The inspector was informed that no complaints had been logged in the centre about the quality and safety of care being provided.

Capacity and capability

Overall the services being provided in this centre were not ensuring a safe quality service for the residents living there. Some of the failings identified at this inspection had already been identified by the provider, notwithstanding considerable improvements were required to ensure that the provider was meeting the

requirements of the regulations.

There were clear governance and management arrangements in the centre. Audits were regularly completed which self identified areas of improvement required in order to provide a safe quality service to the residents. The provider had identified incompatibility issues between some residents which was also contributing to safeguarding concerns in the centre. While the provider had oversight arrangements in place to manage these concerns, the measures implemented were not affecting any substantive changes for residents in the centre.

In addition, the actions in place to address these concerns were not timely and continued to compromise the quality and safety of care in the centre.

For example, the provider had also identified that the designated centre was not suitable to meet the needs of one resident. This had been identified in records dating back to January 2020 and while the resident continued to receive support from numerous allied health professionals, the minutes of meetings viewed indicated that the resident would benefit from a more individualised service. The person in charge had submitted a business case to this effect in June 2020 and was awaiting a response at the time of the inspection.

An unannounced quality and safety review conducted in April 2020 also found that the ongoing issues in the centre were negatively impacting on the lived experiences of the residents. While this review was comprehensive, the inspector found that some of the actions from this had not been completed in a timely manner particularly given the providers concerns. For example: it had been recommended from this review that a compatibility assessment should be conducted in the centre. This was not due to be completed until 30 August 2020. Given the concerns in the centre, this was not timely. In addition, another action had not been completed. This action was to conduct a review of incidents (from October 2019 to March 2020) to try an inform learning; this had not been completed at the time of this inspection and was not due to be completed until August 2020. Again given the concerns in the centre, this was not timely.

A suite of of other audits had been completed in other areas such as infection control, complaints and fire safety. No issues had been noted in these audits with the exception of fire safety. In this audit it had been identified that fire doors in one unit required an upgrade to include self-closure devices. The inspector found that this work was scheduled to take place now that visiting restrictions due to COVID-19 had eased.

The staffing arrangements in the centre needed to be reviewed to ensure consistency of care for residents and to ensure that measures outlined in safeguarding plans and risk assessments could be implemented.

On the day of the inspection only four staff were on duty from 1pm to support four residents. The reason for the staff shortage was because one staff had been required to move to another designated centre on this campus.

As a result the supervision arrangements in place in safeguarding plans and

residents' personal plans could not be maintained with these staffing levels. For example, two staff were supporting one resident on a bus trip. This meant that two staff were supporting three residents in the centre, one of whom was assessed as requiring the support of two staff at all times. In addition, one of two remaining staff also carried an alarm which if sounded required the staff member to leave the centre to assist in an emergency situation in other parts of the campus.

The inspector also found from a review of the actual rota, that it could not be established how many times it occurred when staff were required to go to another centre on the campus as it was not recorded on the actual rota. Staff could not verify this either. However, in a two week time frame in May 2020, twenty one staff had completed shifts in this centre from other areas on the campus. This was not providing consistency of care to residents particularly given that three plans reviewed showed that residents liked familiar staff.

Staff spoken to were familiar with the needs of the residents in the centre and demonstrated a good knowledge of the supports in place for residents. They felt supported in their roles and were aware of the ongoing concerns in the centre.

All staff had been provided with training in order to support residents in the centre. This included fire safety, manual handling, cardio pulmonary resuscitation (CPR) and positive behaviour behaviour support training. While some of training had been postponed due to the restrictions around the delivery of training during COVID-19. The inspector was satisfied that this was outside the control of the provider and was assured from speaking to the clinic nurse manager that training was resuming. For example; fire safety was scheduled to take place next week.

Overall the inspector found that while the provider had identified most of the issues, the actions taken to date had not been timely and were not assuring residents could enjoy and a safe quality service in their home.

Regulation 14: Persons in charge

The person in charge is a qualified nurse and is responsible for two other designated centres under the provider. In order to support them, a clinic nurse manager 2 is also employed full-time in this centre in order to ensure effective oversight of the services being provided.

Judgment: Compliant

Regulation 15: Staffing

The staffing arrangements in the centre needed to be reviewed to ensure consistency of care for residents and to ensure that measures outlined in

safeguarding plans and risk assessments could be implemented.

The actual rota in the centre did always contain the number of staff on duty.

Judgment: Not compliant

Regulation 16: Training and staff development

All staff had been provided with training in order to support residents in the centre. This included fire safety, manual handling, cardio pulmonary resuscitation (CPR) and positive behaviour behaviour support. While some of training had been postponed due to the restrictions around the delivery of training during COVID-19. The inspector was satisfied that this was outside the control of the provider and was assured from speaking to the clinic nurse manager that training was resuming. For example; fire safety was scheduled to take place next week.

Judgment: Compliant

Regulation 23: Governance and management

There were systems in place to manage and review the quality and safety of services being provided in the centre. These systems were identifying areas to improve the quality and safety of care, however some of the actions had not been conducted in a timely manner given the ongoing concerns of the provider.

Judgment: Not compliant

Quality and safety

Overall as stated the inspector found that significant improvements were required to ensure that the provider was meeting the requirements of the regulations and to assure a safe quality service for the residents. The ongoing safeguarding concerns and incompatibility issues were compromising the care and support of residents. Other improvements were also required in risk management, positive behaviour support, communication needs and residents rights.

A sample of residents' personal plans viewed contained an up to date assessment of need, along with detailed support plans to guide residents health care supports. A

sample of plans, found that residents had timely access to a number of allied health professionals including a general health practitioner, psychologist, psychiatrist and a speech and language therapist (specifically for issues relating to food and nutrition only). Residents had also been supported to access national health screening programmes where applicable.

Since the last inspection, the provider had reduced the capacity in the centre to eight residents, this had been outlined in the providers action plan from the last inspection. The provider had also made arrangements for residents to have access to day services. This service had temporarily stopped due the restrictions around COVID-19. Alternatives had been explored and and an activation hall was now available, however residents did not wish to attend this. Some of the plans viewed showed that residents had also developed new goals in the interim, however, as discussed earlier there was limited activities being done in the centre with residents. This was also compromised when staffing levels were reduced in the centre.

Over the course of the inspection, the inspector was informed that residents did not have access to a speech and language therapist to provide supports around their communication needs. One resident was assessed as requiring this support in order to effectively implement interventions to improve their quality of life. Another resident had been referred for support in 2017 to assist with their communication needs and to date no support had been provided.

The provider had measures in place to monitor and review risks in the centre, this included risk assessments and auditing incidents that occurred in the centre on a monthly basis. However, there continued to be a large number of incidents in the centre, which informed the inspector that the control measures in place were not effective.

The provider had taken precautions to manage an outbreak of COVID-19 in the centre. There was posters in the centre, highlighting measures to be taken. Hand sanitisers were available, the provider had identified an isolation unit that could be used in the event of an outbreak. Staff had been provided with training in infection control and personal protective equipment. There were also systems in place to monitor potential symptoms of COVID-19 for residents and staff. Easy read information had been provided for residents and of those met they were aware of the current situation.

All staff had received training in safeguarding training and of those spoken to they were aware of what constituted abuse and what to do in such an event.

There were measures in place to ensure that safeguarding incidents were reported, recorded and reviewed. However, these measures were not effective and as highlighted by the provider through their own audits/ records there continued to be safeguarding incidents in the centre due to the incompatibility of some residents who lived together. As stated the provider had measures to safeguard residents some of which included increased staff supervision, however, these arrangements were not always in place.

An intimate care plan required improvement to ensure that it detailed all of the

supports required for this person, including what staff would provide this support to the resident.

Residents were supported to maintain positive mental health. Staff received training in how to support residents. Staff spoken to were knowledgeable around the needs of the residents. However, one resident who was assessed as requiring significant support and a consistent approach in this area had only an interim plan in place to guide staff. A recommendation had been made in February 2020 to complete a functional assessment to include ABC charts (used to observe and record a persons behaviour), however these charts had only been submitted to the psychologist at the time of the inspection five months later. This interim plan did not adequately guide how staff should respond to this resident in a consistent manner with all of their support needs.

There were systems in place to monitor and oversee the use of restrictive practices in the centre. However, one intervention outlined in a residents plan had not been identified as a restrictive practice and therefore had not been reviewed as such. There was also no plan in place to consistently guide the implementation of this restriction to ensure that the least restrictive measure was used at all times. It was also not clear if residents or their representative had consented to these. For example; according to audits conducted, consent was discussed at residents annual reviews, however records viewed did not have this recorded.

One resident spoken to appeared to be very knowledgeable about their rights. They spoke about their finances and how much rent they paid. They were also informed about the current pandemic health crises and knew about the restrictions in place around this. One issue (identified by the provider) in relation to residents rights needed to be reviewed. This related to residents' finances being held in a central office on the campus.

Regulation 10: Communication

Residents did not have access to a speech and language therapist in order to support their communication needs.

Judgment: Not compliant

Regulation 13: General welfare and development

Since the last inspection day services had been developed for residents to attend. However, this was not available to residents since the COVID-19. Some of the plans viewed showed that residents had developed new goals in the interim, however, there was limited activities available in the centre for residents to partake in should

they wish.

Judgment: Not compliant

Regulation 26: Risk management procedures

The provider had measures in place to monitor and review risks in the centre, this included risk assessments and auditing incidents that occurred in the centre on a monthly basis. However, there continued to be a large number of incidents in the centre, which informed the inspector that the control measures in place were not effective.

A review of incidents as recommended in the providers own audits of the centre had not been conducted in a timely manner

Judgment: Substantially compliant

Regulation 27: Protection against infection

The provider had taken precautions to manage an outbreak of COVID-19 in the centre. There were posters in the centre, highlighting the infection control measures to be taken. Hand sanitisers were available, the provider had identified an isolation unit that could be used in the event of an outbreak. Staff had been provided with training in infection control and personal protective equipment. There were also systems in place to monitor potential symptoms of COVID-19 for residents and staff.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The provider had identified that the designated centre was not suitable to meet the assessed needs of all residents in the centre. This had been highlighted as far back as January 2020 and a business case had only been submitted to seek an alternative placement in June 2020.

Judgment: Not compliant

Regulation 6: Health care

Residents were supported to enjoy good health and had access to a range of allied health supports. However, as discussed under regulation 10 there was no speech and language therapist available for some residents.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents were supported to maintain positive mental health. They had access to a psychologist. However, one resident who was assessed as requiring significant support in this area had only an interim plan in place. A recommendation had been made in February 2020 to complete a functional assessment to include ABC charts (used to observe and record a residents behaviour) however they had only been submitted at the time of the inspection five months later. This interim plan did not adequately guide how staff should respond to support this resident in a consistent manner.

There were systems in place to monitor and oversee the use of restrictive practices in the centre. However, one intervention outlined in a residents plan had not been identified as a restrictive practice and therefore had not been reviewed as such. There was also no plan in place to consistently guide the implementation of this restriction to ensure that the least restrictive measure was used at all times.

It was also not clear if residents or their representative had consented to these. For example; according to audits conducted, consent was discussed at residents annual reviews, however records viewed did not have this recorded.

Judgment: Not compliant

Regulation 8: Protection

There were measures in place to ensure that safeguarding incidents were reported, recorded and reviewed. However, these measures were not effective and as highlighted by the provider through their own audits/ records there continued to be safeguarding incidents in the centre due to the incompatibility of some residents who lived together.

All staff had received training in safeguarding training and of those spoken to were aware of what constituted abuse and what to do in such an event.

An intimate care plan in place to support one resident required review to ensure that included all of the supports required including; what staff would provide those

supports.

Judgment: Not compliant

Regulation 9: Residents' rights

The provider had identified in their own audits in May 2020, that residents finances are kept in a central administration office on the campus. This required action to ensure that residents rights were upheld in the centre.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 10: Communication	Not compliant
Regulation 13: General welfare and development	Not compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Dunwiley & Cloghan OSV-0005489

Inspection ID: MON-0029848

Date of inspection: 13/07/2020

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: To ensure this centre comes into compliance with this regulation the following actions will be undertaken: 1. The PIC will review the staff rosters in line with the Statement of Purpose to ensure there is consistent staff to provide consistency of care for residents and also ensure measures in safeguarding plans and risk assessments are implemented. 2. The PIC will complete an assessment for each resident under Guideline on Assessment, Assignment and Implementation of Safe and Supportive Observation and Supervision Levels for Vulnerable Adults(DIDS 042018) to ensure adequate staffing levels in line with Guideline. 3. The CNM2 and PIC will review rosters on a weekly basis to ensure rosters are reflective of staffing on duty in the centre. 4. A review of rosters is scheduled to take place with the Nursing and Non Nursing Union representatives. 5. The PIC and CNM2 will continue to monitor and review staff training in line with regulations for mandatory training to ensure that all staff have the necessary skills and training in order to support all residents needs.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: To ensure this centre comes into compliance with this regulation the following actions	

will be undertaken:

1. There will be no new admissions to the centre until incompatibility issues are addressed.
2. Compatibility assessments will be completed by MDT members for all residents within the centre.
3. The PIC in conjunction with Estates Department will source suitable accommodation for one resident who requires alternative suitable accommodation.
4. The PIC and CNM2 have completed a review of activities in line with COVID-19 guidelines. The PIC and CNM2 will continue to monitor and review activity schedules for all residents as per Person Centred Plans and continuing COVID-19 guidance.

Regulation 10: Communication	Not Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:
To ensure this centre comes into compliance with this regulation the following actions will be undertaken:
1. Approval has been granted for private SALT assessment for one resident. Assessment process to commence on September 15th 2020.
2. Referrals have been completed for four residents for assessment through SALT for assistive technology. The referrals were completed on August 27th 2020. The referrals were submitted to SALT department.
3. A risk assessment has been escalated by the PIC to the Registered Provider outlining the deficit of this service for residents. This risk assessment has been escalated to the Social Care General Manager.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
To ensure this centre comes into compliance with this regulation the following actions will be undertaken:
1. The PIC and CNM2 have completed a review of activities in line with COVID-19 guidelines. The PIC and CNM2 will continue to monitor and review activity schedules for all residents as per Person Centred Plans and continuing COVID-19 guidance.
2. The PIC and CNM2 will complete a review on a monthly basis of activity records to ensure that the residents are partaking in activities of their choice and accurate records are maintained.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
To ensure this centre comes into compliance with this regulation the following actions will be undertaken:

1. There will be no new admissions to the centre until incompatibility issues are addressed.
2. Compatibility assessments will be completed by MDT members for all residents within the centre.
3. The PIC in conjunction with Estates Department will source suitable accommodation for one resident who requires alternative suitable accommodation.
4. The PIC in conjunction with the CNM2 has completed an audit of all incidents from October 2019 until March 2020 which will inform learning. Audit was completed on 16th July 2020.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
To ensure this centre comes into compliance with this regulation the following actions will be undertaken:

1. There will be no new admissions to the centre until incompatibility issues are addressed.
2. Compatibility assessments will be completed by MDT members for all residents within the centre.
3. The PIC in conjunction with Estates Department will source suitable accommodation for one resident who requires alternative suitable accommodation.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
To ensure this centre comes into compliance with this regulation the following actions will be undertaken:

1. The behavior support plan will be reviewed by the psychologist to ensure that it guides staff on how to respond to the needs of the resident in a consistent manner. This review is scheduled to take place on September 7th 2020.
2. A CNS for behaviours of concern has commenced working with one resident on 24th August 2020.
3. A review of Nursing Intervention and restrictive practice will be completed by the PIC in conjunction with CNM2 and Named Nurse. This review will be conducted in conjunction with the GP.
4. DIDS Annual Review Template has been updated to include a section to ensure discussions around restrictive practices takes place and same is documented at annual review meeting.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
To ensure this centre comes into compliance with this regulation the following actions will be undertaken:
1. There will be no new admissions to the centre until incompatibility issues are addressed.
2. Compatibility assessments will be completed by MDT members for all residents within the centre.
3. The PIC in conjunction with Estates Department will source suitable accommodation for one resident who requires alternative suitable accommodation.
4. Intimate Care Plan for one will be reviewed by named nurse and PIC to ensure that the plan includes all supports required to support the resident.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
To ensure this centre comes into compliance with this regulation the following actions will be undertaken:

1. Financial practices have been reviewed within the centre, each resident now has a cash balance held locally of €50 for day to day expenditure. Money is available for every resident in the administration office in the centre which includes use of a cheque book for their expenditure from their PPP accounts. Residents are supported by staff to access their personal monies in their PPP accounts, including at short notice if required. A quarterly financial statement is available for each resident.

2. Human Rights training has been delivered for a number of staff in the centre, the remaining staff will receive this training once face to face training has recommenced due to COVID 19 restrictions.

In addition, the service is at the early stages of planning for the development of a number of community based houses in conjunction with the County Council and Social Housing representatives. These houses will be equipped with a kitchen which will facilitate residents to prepare their own meals.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Not Compliant	Orange	30/09/2020
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Orange	30/09/2020
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of	Not Compliant	Orange	30/09/2020

	the residents, the statement of purpose and the size and layout of the designated centre.			
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	30/09/2020
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	30/09/2020
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	28/02/2021
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the	Substantially Compliant	Yellow	28/02/2021

	assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	28/02/2021
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	30/09/2020
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	30/09/2020
Regulation 07(5)(c)	The person in charge shall	Substantially Compliant	Yellow	30/09/2020

	ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	28/02/2021
Regulation 08(6)	The person in charge shall have safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.	Substantially Compliant	Yellow	15/10/2020
Regulation 09(1)	The registered provider shall ensure that the designated centre is operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.	Substantially Compliant	Yellow	30/12/2020